



2020 CCDSIG REQUISITION FORM

Please send this form to our P.O. Box or to board@ccdsig.org to request approval for funding for member related expenses. The Finance Committee accepts requests throughout the year but review and approval will occur quarterly. The following guidelines, at a minimum, must be met:

- Reimbursement is a benefit given to dues paying members only and members who participate in fundraising or volunteering.
- Each family may receive up to \$1000.00 per year; up to the limit of available funding.
- The purpose of the expenditure must be directly related to the benefit of the member with Down syndrome, parent/guardian and/or sibling with Down syndrome; such as camp fees, fitness fees, convention fees, seminars, educational classes, etc.
- All expenditures must support our mission -- the UPSIDE of Down syndrome.
- The deadline for each review / approval period is: **3/1, 6/1, 9/1, and 12/1**. Any requisition forms received after the quarterly deadline will be considered during the next period.
- Reimbursement made to the family requires a receipt of payment.
- The finance committee of CCDSIG would like to remind our members that sometimes funding is available thru a variety of other sources, including, school district, county offices insurance and private sources. Please utilize these sources of funding whenever available to insure the CCDSIG reimbursement fund remains available well into the future. Thank you!

Member Name: _____

Date Submitted: _____

Email Address: _____

Reason for request: _____

Amount of expenditure: _____ Date(s) of event: _____ Describe how this will benefit your family or family member with Down syndrome (please be as specific as possible – feel free to include additional pages if necessary).

Funding received to date from CCDSIG: _____

Reimbursement to: Family Provider Receipt attached _____ YES NO

I paid my CCDSIG dues in the current year. YES NO

I volunteered with CCDSIG within the past 12 months. YES NO

The reimbursement check will be sent after the end of the quarterly approval, please allow for this when considering deadlines. To whom should the check be made payable:

Name _____ Address _____

TO BE COMPLETED BY THE FINANCE COMMITTEE

Finance Committee Approval: YES NO

Date Paid _____ Check # _____

Reason(s) for not reimbursing member: _____

Chester County Down Syndrome Interest Group, Inc.	P.O. Box 5064 West Chester, 19380	www.ccdsig.org ccdsig@ccdsig.org
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